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*'The Governance of Pluralist Health Care Systems: An Initial Review and Typology'*

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## *Abstract*

We here argue that study of governance systems within increasingly pluralist health care systems needs to be broadened beyond traditionally public sector orientated literature. We develop an initial typology of multiple governance systems within the English health care sector and derive exploratory questions to inform future empirical investigation. We add to existing literature by considering the co existence of – and possible tensions between – multiple governance systems in a pluralised health and social care system.

### *Introduction: The Pluralization of Health Care – What Are Implications for Its Governance?*

For several decades now, traditionally public sector orientated health care systems in various developed countries have moved towards more diverse forms of service provision. Health policy in England, under various governments, has long favoured developing a more mixed economy on the supply side (1). Similar pluralisation is evident in other jurisdictions such as Nordic countries including Sweden, Denmark and Finland, with traditionally large public sectors (2).

Such pluralization raises the problem of coordination between the increased number of service providers and indeed commissioners (3). This problem can be studied at different levels of analysis. There has been a long standing interest in the creation of integrated care pathways (4) at micro or service delivery level, designed to bring multiple professionals together across whole care processes. But the meso or organizational level should also be considered, as third sector and private sector organizations take on enhanced significance in service delivery. It is possible that the behaviour of professionals in such organizations is (to some extent) steered from the top, from their Boards of Directors and Trustees, which set overall strategic direction. These Boards may be in turn be influenced by their organizations' accountability lines and ownership structures.

The purpose of this small scale personal review is to: (i) identify some texts within various streams of governance literature which go beyond the usual narrow focus on public sector boards; (ii) to construct a typology of the different governance systems which now co exist in

a pluralist health care field and (iii) to explore possible implications and questions for a future empirical study.

Throughout the paper, we use the term ‘governance’ in two distinct ways but both uses are important. Chambers and Cornforth (5) draw a distinction between *organizational level* governance (of particular interest to them) and *wider system level* governance (p99), writing in their piece: ‘the focus here is on the organizational level and the term ‘corporate governance’ will be used to refer to the structures, systems and processes concerned with ensuring the overall direction, control and accountability of an organization.’ Organizational governance here refers to the structure and control systems apparent at the strategic apex of the individual organization, such as a Board of Directors.

‘System level governance’, by contrast, refers a broader political science based analysis of the shift within the United Kingdom away from ‘government’ within an unitary nation state to a more fragmented, diffuse and arms’ length form of ‘governance’ (6, 7). We are interested in both levels: a concrete example of potential systems level governance in the English health care sector is area based coordinating machinery known as Health and Well Being Boards, set up by the 2012 Health and Social Care Act.

The governance perspective directs attention towards the role of Boards or analogous principals in setting overall frameworks and importantly differs from alternative perspectives on decision making, such as: the leadership role of the individual CEO (8); the collective influence of the health care professions operating from below (9) or the dynamics of multi disciplinary teams at service delivery level (10).

### *Approach: An Initial Review*

This is an initial and small scale review and deliberately not a systematic review. Our objective here is to broaden out from a relatively narrow stream of sectorally specific literature on NHS (National Health Service) Boards and open up novel streams of enquiry in a preliminary and creative way. We wished to explore wider streams of governance literature which might be relevant to pluralist health care systems and discuss them together in one paper, thereby helping to link traditionally distinct literature streams. .

We undertook an initial hand search of recent editions (over the last ten years) of a restricted set of relevant journals (e.g. *Voluntas*; *British Journal of Management*; *Public Administration*) and also used the authors' pre existing knowledge of key authors. We snowballed out from these early texts to other references. We here present an initial overview and map of the terrain and hope to develop this early personal review further in future work.

### *The English NHS and Its Changing Corporate Governance Systems*

We start by considering the historically well developed literature on NHS health authority boards which developed as a subtheme within a wider public administration based literature exploring accountability lines in public sector agencies. Most (but not all) NHS board members were historically nominated by ministers rather than being directly elected, unlike local authority councillors (11). Until the 1990 corporate governance reforms (see below), however, NHS District Health Authorities (DHAs) were relatively large and broadly based, consisting of four members appointed by Local Authorities (i.e. councillors); five reserved

places (one each for: a hospital consultant; a GP; a nurse; a trade unionist and a medical school representative) and six or so 'generalists' appointed centrally (11).

Day and Klein's (11) study of these pre 1990 DHAs found they were often problematic settings for their members to influence. Formally, DHA members were accountable upwards to the Regional Health Authorities (RHAs) and then the Secretary of State (the lead Minister); informally, many members reported a (vague) sense of accountability downwards to their local community. DHA members interviewed also often resented the hegemony of the local Senior Management Team (SMT), feeling they lacked both the information and the power to enact their oversight role effectively. Day and Klein (11) were sceptical of their ability to achieve 'role clarity' when compared (for example) to more focussed water authority boards. Day and Klein (11) called for a deliberative process around the developing of Key Performance Indicators (KPIs) to help DHA members make more informed judgements about the overall 'performance' of the organization they were nominally directing.

The health care organizations studied by Day and Klein (11) have since been reorganised, often many times! One difference is indeed a significant growth of KPIs on the lines they recommended. Organizational level data are now summarised and made visible by system regulators (Monitor and Care Quality Commission). Do such data enable current day Non Executive Directors (NEDs) to make more informed assessments about overall performance levels? A second development has been the creation of NHS Foundation Trusts (NHS FTs) (2004 onwards) at local level, and the abolition of DHAs. NHS FTs can be seen as

autonomised 'delivery' organizations and may potentially be less diffuse than their predecessors and therefore their governance may be somewhat less complex.

### *NHS Trusts and NHS Foundation Trusts*

Significant and enduring corporate governance reforms in the 1990 NHS and Community Care Act moved NHS organizations away from the old public administration model of larger boards (11) towards the smaller and more 'business like' boards of the Anglo Saxon private limited firm (Plc). The Act built on the earlier development of internal line management capacity recommended by Griffiths (12) to strengthen the governance level further. The original NHS Trust model (1990) favoured one main board (13), as opposed to the two board model with greater stakeholder representation found in Germany (14). Trade union and local authority representation was culled and Non Executive Directors (NEDs) (note the linguistic shift from the old public administration based term of 'members') appointed, often with private sector experience. The new boards were encouraged to set strategic direction and ensure high performance within a single autonomized provider organization, although still subject to external regulation. A second stream of generic strategic management literature on private sector boards now became more relevant (15) to these more market facing and competitive NHS Trusts. They originally operated in an internal quasi market within the NHS (1990-97). However, the recent 2012 Health and Social Care Act has stimulated more market entry from private and third sector entrants so a more open market is developing in some sectors (e.g. in community health services). The 2012 Act also relaxed the cap on privately generated income for NHSFTs so they are becoming more of a 'hybrid' between a public agency and private firm. They can make and retain a surplus from private income generating activities, although there are (as yet) no shareholders or dividends to pay. NHS Trust NEDs

(from 1990) were appointed by the Department of Health or later its advisory agencies on the basis of personal expertise and drive and not elected and previous representation from nominated local authority councillors and medical and allied representatives at DHA level was weakened (16). FT boards became smaller, tighter, and supposedly more 'strategic'.

This 'democratic deficit' was criticised by some political scientists such as Skelcher (17) as an (important) component of a larger trend in UK public management reform which had expanded the scope of non elected, arm's length, agencies ('quangos') across the public services and shrunk the powers of elected local government in favour of a greater role for central government and its agencies. Much of local government was of course controlled by opposition political parties, including the Labour Party so these governance reforms also cut back on the political opposition's power base. This third and more critical literature stream maps the changing shape of the contemporary state (including its manifestations in the health care sector), exploring the alleged growth of quangos and a weakening of direct democratic accountability at local level. The health care state is construed here as one which is appointed rather than directly elected but also one in charge of major and visible public services and large budgets. The focus in this literature is on championing locally based democratic forms of governance as opposed to a 'patronage state' or indeed other forms of participation, such as Public and Patient Involvement (PPI), (18) which do not however have a direct presence at Board level.

Perhaps as a response to this critique, reforms brought in during in the New Labour period (1997/2010) rebalanced at least somewhat the governance of NHS Foundation Trusts (set up from 2004 onwards) by creating a second board of Governors drawn from community and



staff groupings alongside the appointed main board. These governors related to different constituencies of members (14). The Governors formally had the power to appoint the non executive chair and NEDs. These NHS FTs (19, 20) have been described as taking the form of a not for profit, public benefit corporation and as based on a mutual ownership model. Some of their ‘constituencies’ held elections and there was now to be at least one governor representing Local Authorities.

The main board could now in principle be held accountable downwards to local Governors as well as upwards to the national regulator (Monitor), acting on behalf of the Secretary of State. The new Governors, however, still seem to be struggling to negotiate an effective role and to be under utilized (14), suggesting that the main Trust board may remain as a more significant power centre, partly because it retains legal accountability

In short, the current governance arrangements of NHS FTs mix various elements within ‘hybrid’ forms. The small, private sector style and supposedly strategic Boards of the 1990 reforms have been retained and they still strongly face ‘upwards’ to the regulator (Monitor). At the same time, they now also face downwards to their Governors, although this downwards accountability appears as yet still weakly developed. They remain public bodies without shareholders, although they can make and retain surpluses and the cap on private income generation was relaxed in the 2012 Act. Some Trusts now have ambitious plans to develop private income streams, including at the international level so their private patients units are expanding and are becoming more ‘firm like’. NHS FTs are facing more open markets so it is unclear whether they will now adopt more competitive behaviours, or

whether they will instead seek to act as local coordinators or ‘system leaders’ and if so, what their capacity for systems thinking as opposed to a more competitive strategy is.

### *The Governance of NHS Primary Care: Commissioners and Providers*

We now consider NHS primary care, which contains both commissioning and providing organizations. Between 1990 and 2012, various incarnations of NHS primary care commissioning organizations broadly adopted a similar model to NHS hospital Trusts, with non executive members and a non executive chair. However, there were here fewer executive members. Some literature which explored primary care boards found they were largely ineffective in setting a clear strategic direction (21).

Clinical Commissioning Groups (CCGs) (established by the 2012 Health and Social Care Act) were designed to increase the influence of primary care health professionals on local commissioning and reduce managerial/bureaucratic control. CCG Boards have a high representation from GPs, and a lower non executive presence (a minimum of two lay members). They are membership based organizations representing all local general practices who elect representatives so they now have a ‘governing body’ model rather than a Board. We ask: will such a membership based organization behave in a more collective and consensus seeking way than a firm like one based on principal/agent (board/employee) relationships?

Checkland et al (3) found the emergent CCGs (p9) faced in practice a ‘complex web of accountability relationships’. They still had a (strong) upwards accountability line to the

Department of Health and the sector regulator. They have also a downwards facing but weakly expressed line of accountability to their patients and local population. ‘CCGs are membership based organizations and this is said to be one of the key strengths of the new structures’ (Checkland et al, p7) (3) yet downwards facing accountability lines to the local practices were as yet poorly specified. We clearly need to know more about how the governance of CCGs develops and how this distinctive membership based form of organizing (and opposed to a hierarchical form) plays out in practice.

We also know little about the operation of governance systems *within* the general practices which provide frontline primary care services. Such settings are often professional partnership based organizations where senior professionals (usually GPs) are simultaneously owners, employers and managers. This professional partnership form is radically different from both conventional public agencies (where employees are salaried) and private firms owned by shareholders. Some GP practices have rapidly grown through mergers and acquisitions, perhaps acquiring more poorly performing practices, and are now large scale organizations with an extended group of partners (22). In addition, some General Practices are coming together within loose federations rather than formal mergers.

The 1998 Primary Care Act liberalised workforce arrangements so non doctors (e.g. a nurse or practice managers) can now become partners (although numbers are still small). There has been a significant growth in the number of salaried GPs alongside traditional partners. So there are significant changes in the primary care workforce. Recent legislation (2010) also allows practices to become limited liability companies to limit partners’ potential liabilities and encourage more capital investment. Corporately owned chains and outsourcing

companies are now moving into English primary care, including Virgin care and SERCO (15), representing a significant new organizational form and one with more firm like governance systems.

In a rare example of primary care orientated organizational research, Sheaff (23) suggests traditional primary care partnerships will seek to balance multiple objectives, satisfying partners' expectations about income but also sensitive to professional opinions about the range and quality of services and sustaining collegial working. After undertaking case studies on decision making in these settings, Sheaff et al, (24) (p142) concluded: 'the general practices we studied had a common sequence for decision making. Closed partners' meetings first made a decision, followed by discussion with the employees, usually at periodic practice meetings. Internally, the partners' meetings generally worked by consensus.' Partnerships could also develop their own management style: the nurse led practice they studied, for example, had a more open style with strong consultation with salaried staff. McDonald et al (25) found that a new and more performance related contract had informally led to the emergence of so called 'chaser groups' of GPs who actively monitored the performance of staff, including partners, in meeting key income related targets. These 'chasers' were often (but not always) partners and often (but not always) members of local boards so that it was possible that there was some element of novelty in the construction of these 'chaser' roles.

So we need more research on general practices' governance. Are lead partner or even managing director roles emerging – especially in larger multi site practices - or is the old rotation principle surviving (Sheaff et al (24) found examples of both forms)? Are informal 'chaser' groups of GPs also emerging (25)? How do groups of partners make strategic

decisions about the overall direction of the practice? Who becomes a partner and how? How do the big private firms now moving into primary care operate in governance terms?

### *Boards in The Private Sector Firm*

We have argued that some NHS governance systems (e.g. NHS FTs) are primarily modelled on the Anglo Saxon Plc, albeit with minor recent rebalancing from German style stakeholder based models. So accessing studies of ‘effective boards’ in the private sector (26) might now be helpful to NHS FT Boards too. The ‘managerial hegemony’ thesis (27) in this literature on private sector firms, for example, has already been used within studies designed to assess the strategic impact of NHS NEDs (15, 16).

Given marketization policies, various forms of private sector ownership are apparent in the current health care sector. Most obviously, private firms listed on the stock exchange and with shareholders who expect dividends play an increasing role in English health care delivery, including some large outsourcing firms (e.g. SERCO Plc). There is now also a well established private sector presence in long term nursing and residential care, with large chains emerging alongside traditional cottage industry provision (e.g. Four Seasons Health Care chain, recently bought by Terra Firma private equity). The presence of private equity funds in the nursing homes sector is then significant; although the market currently seems fragile. Of course, more traditional family based ownership structures may also persist (e.g. in smaller groupings of nursing and residential care homes).

Formally, company strategy in Plcs is set by the board, held accountable by its shareholders at the Annual General Meeting (AGM). Within the Anglo Saxon model, shareholders are seen as more central than other stakeholders. So healthcare management scholars should now pay more attention to the substantial academic literature on corporate governance in Plcs, both on boards and their regulation. There is a need to consider spill over effects from reports of enquiry and reforms designed to improve corporate governance (27) in the private sector evident in the UK from the 1990s onwards, for the public sector, as similar reforms may diffuse across sectoral boundaries.

So we conclude that the PLC based form is important, but we suggest other types of firm may also now be present in the health care sector. Is a distinctive governance effect exercised by private equity and venture capital funds, as in the nursing home sector? Do SMEs owned by families in the health care sector (e.g. smaller groupings of nursing or residential homes) behave in distinctive ways in governance terms?

Recent academic work on NHS corporate governance reveals a helpful shift of perspective in now citing generic corporate governance texts as well as health sector based studies. Chambers' (13) overview (also 28) thus helpfully reviews general theories of corporate governance, such as agency theory (where the board is the principal and senior managers their agents) and stewardship theory (where the board and managers work together in the long term interest of the company). Successive reforms to UK Plcs have tried to expand NEDs' roles to ensure better governance. There is an increased academic interest in exploring board processes – and how NEDs can carve out real influence on boards – in private firms as well as a more legalistic focus on formal board structure (29, 30). Within the NHS, the more

micro level and interactionist ‘enactment’ perspective on board behaviour was explored by Freeman et al (31).

In summary, we suggest we need more analyses of the governance of Plcs operating in the private health care sector and follow the operation of lines of accountability down to shareholders or their proxies (such as investment funds and financial advisers) (32, 33), considering how they affect important matters such as dividend policy or shareholder value (34). Other questions include: do the Boards of these Plcs in health care operate with a shareholder or stakeholder model? How do they interact with sectoral regulators and other non private sector players in the health and social care system?

#### *Local Government and The Direct Democratic Mode of Accountability*

Local government is a major and perhaps increasingly important partner for English health care in such important areas as: public health, adult social care and children’s services. The 2012 Act transferred responsibility for the public health function to Local Authorities. New Local Authority based Health and Well Being Boards were set up and are charged with setting strategic direction across a geographic area. CCGs have members on these Boards and in formal terms should set their own priorities in response to these Boards’ strategic direction (3).

However, accountability modes have been seen by some political scientists (35) as radically different in local government from the health care sector as its basic principle is the direct democratic election of councillors rather than indirect appointments of non executives from

ministers (as we consider further below). The system of party political control in English local government often ensures one majority political party forms an administration and seeks to implement a collective electoral mandate. In cases of poor performance, the national centre also finds it more difficult to replace elected political leaders than to remove appointed managers and Boards, as it readily can in the NHS.

The governance model (28) in this sector is that elected members (councillors) work collectively as a non executive council, supported by professional and neutral officers. Reflecting disquiet about poor quality of decision making in traditional committee based models, the UK Local Government Act (2000) proposed various reform models which all sought to increase levels of political/executive authority, such as a visible leader and a small cabinet of senior councillors with major policy briefs (e.g. Social Services) (28).

Some political scientists (35) have criticized the growth of ‘quangos’ or the ‘appointed state’ apparent as a result of NPM reforms in the 1980s and 1990s (e.g. the removal of the New Universities from local government control in 1992 and their reconstruction as independent and autonomised corporations). Local government is seen as better in generating direct face to face democratic dialogue and accountability; bottom up feedback and community self governance than such autonomised and self standing agencies with their Boards appointed by the centre. One suggestion is that functions with significant policy responsibility (e.g. health) (36, p164) should be moved into the elected sector to enrich modes of accountability.

However, some empirical studies – such as a 2003 study of governance across the North East region (36) - found still significant weaknesses in the democratic credibility – and hence



possibly legitimacy - of local government: for example, turnouts at elections were low and the candidate pool was narrow. In many (but not all) areas there was little effective electoral competition as many councils are 'safe' for a political party. Between elections, there might therefore be weak 'downwards facing' accountability from councillors to their voters. Given weak electoral competition and low voter turnout, councils' political mandates may be seen as weak. However, some empirical work suggests fear of losses in forthcoming elections can act as a credible threat which spurs pre-emptive and self-initiated action by senior political leaders to improve council performance (37) and their own electoral prospects.

This local government literature is widely informed by political science based thinking (35), often advocating enhanced democratic control and downsizing of appointed bodies or 'quangos': 'in our view, the basic issue is democratic control. Most, if not all the unelected bodies should be replaced by elected ones as a matter of principle to provide the basis for accountability' (36, p37). There is an interest in stimulating 'downwards facing' modes of accountability and better developed citizen based (more extensive than restricted notions of consumer choice) participation (38).

One implication is that current attempts to integrate health and social care provision (e.g. devolution to the Manchester region) (39) may need to handle tensions caused by the distinctive governance regimes and indeed electoral cycles in the different sectors involved. Empirical questions include: how are local authority Cabinet Members constructing their roles? How do they interact with health care? Has local government become more sophisticated in its downwards facing public consultation processes?

### *The Third Sector: The Role of Boards of Trustees*

Third sector organizations are often governed through an (unpaid) Board of Trustees. Of course, there is substantial variety between subgroups of third sector organizations. While many such organizations are small scale and locally based, some others have become large scale and significant players in English health care, often working under contract to deliver services for NHS commissioners (e.g. Age UK) (40). There have been attempts to professionalise the governance of the sector, with more codes of conduct being produced by national bodies and the Charity Commission exercising increasing oversight.

One danger for third sector service providers is that they become over dependent on government funding and lose their core identity (41). The centrality of ‘mission’ here makes conventional models of corporate governance problematic. These organizations also have a frequent need to motivate their volunteer base. They lack both a profit motive and public sector based performance management systems as organizational disciplines. They also have sectorally specific income generation strategies (e.g. time limited campaigns; donations; charity shops) and growing flows of private income may push them towards becoming ‘hybrids’ in both financial and governance terms (41), now trying to mix market like and voluntaristic principles (e.g. a commercial subboard which reports to a voluntaristic main board). The growing literature on hybrid organizational forms (42) raises the question as to whether hybrid governance regimes are stable – especially where private income flows expand over and above charitable or public sources of funding – or whether one governance principle in the end becomes dominant.

English third sector organizations are typically governed by volunteer Boards of Trustees, as opposed to Boards of Directors, elected at AGMs by all members. These organizations are regulated by the UK Charities Commission. However governance weaknesses are empirically apparent. Small third sector organizations are vulnerable at both managerial and governance levels to over dependence on a small and static ‘inner circle’, often with succession planning issues (40). Survey based evidence that larger charities provide more support and training to board members (43) suggests that the consolidation now evident in the sector might produce larger and better governed organizations

Concern about the robustness of these traditional governance structures is evident in the recent Myners review (44) of the large UK based Cooperative group (following major financial losses) which urged it to move from traditional representative governance structures to a smaller, expert, board with stronger financial management. Third sector governance has historically been a relatively narrow academic field, but there are now calls from scholars to broaden its theoretical perspectives (45).

Social enterprises represent a growing subsector within the third sector, where a diverse and indeed complex range of governance arrangements appears possible. Social enterprises may take the form of private firms with explicit social goals, normally governed by a Board of Directors or a founder owner in the case of a SME. They may also take the form of large trusts or philanthropic divisions of large firms, normally governed by Trustees. They could take the form of worker cooperatives (mutuals) or social cooperatives which involve both client and worker groups within the co production of services. They may finally represent another example of a ‘hybrid form’, for example, where a large NGO sets up a for profit

subsidiary for income generation purposes. Its for profit operations may then be ringfenced organizationally, reporting to a sub board which then is subject to oversight from the main board of the NGO. Young (46) suggests both that the current empirically based literature on social enterprises is thin and that theoretically it is possible that any such hybrid governance forms are unstable and that governance reverts to one dominant ideal type.

#### *Area based Coordinating mechanisms and processes*

The so called ‘network governance’ (NG) narrative of public and health management reform (7, 47), sponsored by post NPM authors and then New Labour governments (1997-2010), promoted more integrated and systemic approaches to public services delivery designed to unpick the fragmenting effects of earlier market/management led (‘New Public Management’) reforms sponsored by Conservative governments. Some of these NG reforms tried to reinforce the operation of a geographically based system of public services delivery. Within health care, a good example of such Network Governance reforms were the place based Health Action Zones (HAZs) of the early 2000s, although Bauld et al’s study (48) suggested empirically they achieved only mixed results. Some other managed network forms in health care – such as the cancer networks that emerged as local responses in some areas in the mid 1990s, were inherited by New Labour in 1997 but then strongly developed and made mandatory (49, p74) by them – have however survived a review after the move back to Conservative led governments in 2010 and endured (49). Stoker (50) suggests a new model of ‘community governance’ may evolve where local authorities – as opposed to NHS FTs - take on broader roles as system developers, even where they lose responsibility for direct service provision.

Newly elected Conservative led governments in 2010 and again in 2015 re tilted English health policy back to marketization. So autonomised NHS FTs may possibly now retreat from collaboration and move back towards principles of competition. Nevertheless, there are still attempts to develop inter agency working, especially between health and social care. Specifically, the new Health and Well Being boards set up in 2013 should bring health and social care agencies together to consider local populations' needs (51). While health care budgets have been relatively protected since 2010, however, local authority budgets (including adult social care) are under severe pressure, possibly encouraging a dysfunctional shift of the balance of care of older and other patients/clients from social to health care settings (despite official policy), especially into Accident and Emergency settings where it is difficult to curtail direct access. This is also only the latest cycle of reform in a policy arena which has resisted various earlier attempts to promote more systemic working.

There is now an emerging public health orientated literature on these Health and Well Being Boards which have been formally set up as statutory committees of local authorities.

Coleman et al (2014) (52)'s study of 8 early 'shadow' boards suggested a number of difficult issues arose: (i) lack of executive power; (ii) unclear accountability lines; (iii) some tensions with primary care and CCGs; (iv) difficulties in getting local issues on overloaded agendas; (v) the lack of experience of NHS staff in handling overtly political arenas (e.g. change of party control after elections); and (vi) different planning, financing and governance systems in the different organizations involved.

Marks et al (53)'s early study explored as one theme the organizational context of these Boards' decision making, noting (p1201): 'perhaps ironically given that local government is

often seen as the natural home for public health, the study exposed differences between NHS based public health and local authority public health in views over evidence, priority setting processes and the role of democratic decision making....'. It was noted that both process values (views about accountability and participation) and content values (decision making criteria) strongly informed what were termed the 'values and politics of public health.'

So we need more empirical evidence about how these coordinating Boards are now operating in practice and their influence levels, given they do not hold budgets or have line management power. From a governance perspective, we ask: are there 'board interlocks' present in the health and social care sector with a few well connected nominees on multiple boards, replicating what some private sector board literature suggests (54)? Or do different subgroups of board members form with little interaction? Social Network analysis could be usefully employed to address these questions.

While some traditionally influential health care providers (large NHS FTs) now claim to be local 'system integrators', is this claim accepted by partners or seen as just another claim and iteration in long standing institutional dominance? Are local authorities, instead, developing wider community governance roles (50) which then seek to incorporate the health sector?

Finally, NHS England (2016) is encouraging health and social care leaders across local systems to come together to produce Sustainability and Transformation Plans to cope with intense productivity pressures. These new partnerships should also be studied once they have been fully set up.

## *Concluding Discussion*

Our key argument is that health management scholars interested in exploring the governance of more pluralist health care systems should broaden their analyses to go beyond: (i) the traditional focus on public services boards; and (ii) the already developing interest in boards of large firms; to include more literature on: (iii) professional partnership forms (e.g. primary care; dentistry); (iv) democratically based modes of accountability in local government (e.g. social care); (v) the role of Trustees in governing third sector organizations; (vi) the nature of any whole area coordinating machinery across local systems.

While we have here explored the governance of the English system, similar issues arise in other health systems where the traditional public sector is also in long term decline. The Nordic countries are here good comparators as they shift from their old government centric model (2, 55, 56, 57). Other countries – such as Germany – display alternative models of stakeholder based governance in private firms which are of interest and may have influenced the redesign of NHS FTs governance systems.

This early scoping paper should hopefully inform the design of a projected empirically grounded study on the operation of multiple governance systems in one large English health and social care economy with a history of trying to develop integrated care across organizational boundaries. Table 1 picks out some questions which arise from this initial literature review which might inform an empirical study of the operation of multiple governance systems in this sector. This projected empirical study hopes to focus on services for older people as a multi organizational policy field of major policy and resource

importance. This early literature review indicates there is a need for such empirical studies in contemporary pluralised settings and on a whole area basis to explore the interactions between different governance systems which goes beyond the conventional focus on micro level service delivery level interactions.

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*Table 1: Questions Arising From the Literature Review for a Possible Study of Governance Systems in A Pluralised English Health and Social Care system*

## NHS Organizations

|                     | NHS Foundation Trusts   | Clinical Commissioning Groups  | General Practices  |
|---------------------|---|--|--|
| Organizational Form | Autonomised and decentralised provider units;<br>Public benefit corporation with an element of mutuality;   | Commissioning arm across local populations;  | Local and traditionally small scale providers of primary care services;<br>Some recent ‘scaling up’, mergers and acquisitions; |
| Financial Flows     | Mainly public money;<br>No shareholders or dividends;<br>BUT can make and retain surpluses;<br>increased ability to raise private income;                               | Public money;<br>Under increasing financial stress following post 2008 austerity;      | Mainly public money; some private practice and ‘spin off’ businesses;  |
| Governance          | Two tier board:<br>Council of Governors and powerful main Board (Non executives and executives);<br><br>Supervised by regulators (Monitor and Care Quality Commission); | Membership organization for all local general practices;                               | Professional partnership form;<br>Regulated by CCGs and the Care Quality Commission;   |
| Issues Arising      | Different governance systems and accountabilities; which is dominant in practice?;  | Strongly supervised by NHS England;<br>Multiple accountabilities; which is dominant in | Who makes major decisions?<br>Role of partners?<br>Role of the regulator (CQC)?  |



|  |   |   |  |
|--|---|---|--|
|  | Collaborative or competitive strategy locally?<br>Strength of systems based thinking? | practice?<br>Small scale or large scale thinking? |  |
|--|---|---|--|

### Further Sectors and Actors

|                     | Local Authority  | Third sector   | Private Sector   | Health and Well Being Boards  |
|---------------------|--|--|--|---|
| Organizational Form | Democratically elected local body;<br>Party political control;   | Not for profits;<br>Range of forms: NGOs; Social enterprises;<br>Cooperatives;<br>Strong volunteer element and sense of mission; | Private firms: diverse range – SMES; PLCs, MNCs;<br>outsourcing firms; private equity funds (e.g. nursing home sector)   | Statutory inter agency and area based coordinating machinery set up by 2012 Act for health and local government agencies; |
| Financial Flows     | Local taxation plus central government financial support   | Donors;<br>Public grants;<br>Some private income generation (e.g. charity shops);  | Markets and customers;<br>Some public sector contracts for outsourcing firms;  | No financial responsibilities   |
| Governance          | Councillors;<br>Party system;<br>Now Cabinet System and Mayors in some areas;  | Boards of Trustees;<br>Regulated by the Charity Commission;  | Often Boards of Directors who report to shareholders at AGM;<br>Regulator;   | Inter agency forum;   |
| Issues Arising      | Strength of democratic accountability;<br>Interaction with other 'non democratic' sectors';<br>Key importance of adult social care function; | Strength of governance systems;<br>Dependence on public grants;  | Shareholder or stakeholder model?<br>Spot contracts or relational contracts?<br>Degree of long term or systems thinking? | Degree of private and 3 <sup>rd</sup> sector involvement?<br>Degree and nature of their influence ?                       |